LETTERS TO THE EDITOR

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DENTAL PATIENTS

Tossing for it

Sir, a 70-year-old gentleman was referred by his dentist for an opinion on a grossly decayed unrestorable, albeit symptomless, lower left wisdom tooth (38). I discussed with the patient the options open to him: either surgical removal of the tooth before any symptoms occurred or leaving it until symptoms occurred and then removing it.

I advised the former and invited the gentleman to choose. He calmly took a coin out of his pocket. 'Tails, I leave it; heads, I have the tooth out,' said he. Lo and behold it was tails! I said to myself this is shared decision-making and autonomy at work – the kind I have not come across in my 32+ years of clinical practice. By the way I did not check the coin for possible bias!

S. Appiah-Anane, by email
DOI: 10.1038/sj.bdj.2014.1104

Mass in a crypt

Sir, a 42-year-old female attended my surgery for an emergency appointment, complaining of a swelling in her throat. This swelling appeared sporadically, and was most perceptible immediately after eating. Following two visits to her GP, who found nothing on examination, she felt I was her last resort as she was becoming increasingly frustrated by the irritating sensation when swallowing. My examination revealed extremely large but healthy tonsils. Thanks to her patience and lack of pharyngeal reflex, I was able to see a single white mass present in a crypt of her right tonsil. My initial impression, due to its irregular occurrence and soft lumpy appearance was either food debris or perhaps a tonsil stone (although she had no history of tonsillitis).

As a foundation dentist, I have had little experience in this area. Fortunately, I had seen an episode of Channel 4's 'Embarrassing Bodies' where a patient had experienced a similar problem. I removed the mass carefully with a cotton bud. It was indeed food debris, accumulating most likely due to her large tonsils. I advised her to adopt this method in the future, along with salt-water mouth rinses, and I also sent a letter to the GP.

The patient was relieved and extremely grateful to have a solution to this frustrating problem, which she has lived with for a number of years. However, I felt it best not to tell her where I came across the answer!

L. Duffy, by email
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PERIODONTOLOGY

Antibiotics protocol

Sir, recently, dental practitioners have noticed the significant changes in the newest version of the British National Formulary, regarding antibiotics protocol for dental conditions. According to the BNF recommendations[1] the systemic treatment of severe cases of periodontitis, resistant to mechanical debridement, can be based on mono-drug therapy with the use of metronidazole (alternative: doxycycline), the bactericidal agent targeting the gram-negative strict anaerobes from the 'red' and 'orange' Socransky complexes.

Despite the high efficiacy of metronidazole against anaerobic bacteria, particularly *P. gingivalis and Prevotella intermedia*,[2] alone it has a limited effect against periopathogen *Aggregatibacter actinomycetemcomitans* (reclassified *Actinobacillus actinomycetemcomitans*), which is a facultative rather than a strict anaerobe and it is considered as the main causative factor in aggressive periodontitis.[3-5] *Actinomyces*, *Streptococcus* and *Capnocytophaga* are also reported to be minimally affected by metronidazole.[6]

Chronic periodontitis is caused by a mixed microbial infection making the selection of targeted antibiotic difficult to justify. No single antibiotic with a relatively narrow spectrum of antibacterial activity can be effective against all periopathogens. Periodontal infections are represented by a broad diversity of periopathogens, including anaerobic, microaerophilic, and aerobic bacteria, both Gram negative and Gram positive. Hence, it is recommended to use more than one antibiotic with different antibacterial spectra.

The combination of metronidazole-amoxicillin and metronidazole plus amoxicillin-clavulanate potassium seems to be the most effective antimicrobial therapy in the management of advanced periodontitis.[2,7,8] Amoxicillin reveals broader spectrum decreasing counts of Gram negative anaerobes, including also *Aggregatibacter*. This provides an elimination of bacteria in aggressive periodontitis that had been treated unsuccessfully with mechanical debridement and other, single antibiotics.

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1. British National Formulary. Table 1. Summary of antibacterial therapy for ear, nose, and oropharynx. https://www.medicinescomplete.com/mc/bnf/current/PHP3268-ear-nose-and-oropharynx.htm
2. Prakasam A, Elavarasu S S, Natarajan R K. Antibiotics in the management of aggressive periodontitis. *J Pharm Bioallied Sci* 2012; **4(Suppl 2):** S252–255.
3. Herrera D, Alonso B, León R, Roldán S, Sanz M. Antimicrobial therapy in periodontitis: the use of systemic antimicrobials against the subgingival biofilm. *J Clin Periodontol* 2008; **35(8 Suppl):** 45–66.
4. Heitz-Mayfield L J. Systemic antibiotics in periodontal therapy. *Aust Dent J* 2009; **54 Suppl 1:** S96–101.
5. Guerrero A, Griffiths G S, Nibali L. Adjunctive benefits of systemic amoxicillin and metronidazole in non-surgical treatment of generalized aggressive periodontitis: a randomized placebo controlled clinical trial. *J Clin Periodontol* 2005; **32:** 1096–1107.
6. Feres M, Haffajee A D, Allard K, Som S, Socransky S S. Change in subgingival microbial profiles in adult periodontitis subjects receiving either systemically-administered amoxicillin or metronidazole. *J Clin Periodontol* 2001; **28:** 597–609.
7. Winkel E G, Van Winkelhoff A J, Timmerman M F, Van der Velden U, Van der Weijden G A. Amoxicillin plus metronidazole in the treatment of adult periodontitis patients. A double-blind placebo-controlled study. *J Clin Periodontol* 2001; **28:** 296-–05.
8. Flemmig T F, Milian E, Kopp C, Karch H, Klaiber B. Differential effects of systemic metronidazole and amoxicillin on Actinobacillus actinomycetemcomitans and Porphyromonas gingivalis in intraoral habitats. *J Clin Periodontol* 1998; **25:** 1–10.

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ORAL MEDICINE

Off-label cream use

Sir, we write in response to the letter *Erosive lichen planus* (*BDJ* 2014; **216:** 545).

Erosive and ulcerative lesions of oral lichen planus (OLP) can be persistent and painful;[1] therapy is warranted when patients have painful disease that may adversely impact upon quality of life, but effective management of OLP can be challenging.[2] The letter's authors presented their recent preliminary experience